

DEPARTMENT OF MENTAL HEALTH

REQUEST FOR REASONABLE ACCOMMODATION

Applicant/Employee Name _____ Date _____

Disability _____

POSITION _____

Office Location _____

Supervisor _____ Phone _____

(Complete the Appropriate Section)

A. Building Access: _____

B. Job Restructuring: _____

C. Purchase or Modification of Equipment or Devices: _____

D. Work-Related Personal Accommodations: _____

Recommendations: (Include justification of job relatedness and effectiveness, cost, and other pertinent information.)

To be Completed by Line Manager:

ACCOMMODATION APPROVED – ACTION TAKEN

(If the accommodation to be provided is different from the one proposed, explain why.)

ACCOMMODATION DENIED – ACTION TAKEN

(Include reasons for denial. If based on undue hardship, explain in what way the proposed accommodation would create a hardship.)

Employee/Applicant's Signature

Date

Immediate Supervisor's Signature

Date

Deputy Director's Signature

Date

Noted and Reviewed: _____
DMH Health Officer

Date